EuroHealthNet

EUROPEAN PARTNERSHIP FOR IMPROVING HEALTH, EQUITY & WELLBEING

Health Promotion and Disease Prevention Best Practice Portals

Cologne, Germany

11-12 June 2019

BZgA Bundeszentrale für gesundheitliche Aufklärung

Contents

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1 Summary

EuroHealthNet and the German Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, BZgA) held an expert workshop on health promotion best practice portals on 11-12 June 2019 in Cologne, Germany. The workshop had the following goals:

1. Share the various approaches currently used for developing best practice portals and discuss their successes and challenges.
2. Discuss the assessment criteria for evaluating best practices, including how to make the portal inclusive while maintaining high quality.
3. Address issues of evidence, including how core elements of effective interventions are identified. Discuss scalability and replicability of best practices, and how to organize information on 'what works' in health promotion by theme and target group.
4. Exchange ideas for stimulating the use and promotion of best practice portals and their associated interventions. Address the user experience from both the intervention owner and public health worker perspectives. Explore added value of joint European approaches (including both joint approaches between national and with the European Commission).

The workshop brought together national and international specialists to discuss the challenges national policy makers and national public health bodies face in establishing, maintaining and mainstreaming the use and usability of best practice portals, or programme registers which collect health promotion and disease prevention practices at national and European level.

The workshop included participants from BZgA, RIVM (the Netherlands National Institute for Public Health and the Environment), Santé publique France (the French Agency for Public Health), DoRS (Piedmont Regional Health Promotion Documentation Centre, Italy), Gezond Leven (the Flemish Institute for Healthy Living), THL (the Finnish National Institute for Health and Wellbeing), NIJZ (the Slovenian National Institute of Public Health), the National Institute of Hygiene of Poland, the Ministry of Health of Lithuania, Radboud University Medical Centre, as well as external participants from the Directorate General for Health and Food Safety (DG SANTE), the Directorate General Joint Research Centre (JRC), the University of Colorado Boulder, and the French Agence Nouvelle des Solidarités Actives.

Workshop participants conducted an overview of the current development of national best practice portals in several European countries, heard about the European Commission's Best Practice Portal of the Steering Group on Health Promotion and Disease Prevention, discussed assessment criteria for evaluating and identifying suitable interventions, and heard case studies from the What Works Centre (France) and the Blueprints Programme (USA). They also discussed cost-effectiveness of portals and conducted breakout sessions to discuss the potential for future joint work and collaboration. The workshop concluded with a discussion of next steps, including the formation of a thematic working group (TWIG) and opportunities to continue liaison with the European Commission's European Best Practice Portal.

2 Agenda

	Day One
	Moderators: Alison Maassen, EuroHealthNet, and Yvette Shajanian-Zarneh, BZgA
09:00 – 9:30	Welcome to introductions *Martin Dietrich, Deputy Director, BZgA* *Alison Maassen, Senior Coordinator, EuroHealthNet*
9:30 – 11:00	Overview of current development of national best practice portals *France, Pierre Arwidson, Sante publique France* *Germany, Freia DeBock, BZgA* *The Netherlands, Karlijn Leenaars, RIVM* *Slovenia, Sandra Rados-Krnel, NIJZ* *Italy, Paola Ragazzoni, DORS, Piedmont* Q&A on national best practice portals
11:00 – 11:30	Presentation of the Best Practices Portal of the Steering Group on Health Promotion and Disease Prevention of the European Commission. *Ingrid Keller, Directorate General for Health and Food Safety, European Commission*
11:30 – 11:50	Coffee Break
11:50 – 13:00	Assessment criteria for evaluating and identifying suitable interventions for health promotion best practices - *The Current State and Challenges of Prevention Registries – Karl G. Hill, Blueprints for Healthy Youth Development, University of Colorado Boulder* - *How to assess the evidence base? – Freia DeBock, BZgA*
13:00	Lunch
14:00 – 14:25	What Works Centres for evidence-based policies in France *Ben Rickey, ANSA (the New Agency for Active Solidarities)*
14:25 – 15:30	Translating best practice interventions into implementation: addressing the scalability, replicability and other aspects of transferability, and practical

	concerns of applying the knowledge and improving implementation: Presentation and discussion *Djoeke van Dale, RIVM*
15:30	Coffee Break
16:00 – 17:00	Where do we stand? What are common topics? Reflection and discussion in two breakout groups: - Successes & challenges of developing and designing best practice portals - Why currently (rather) good practice but evidence/quality - Gaps between evidence and practice: How to move from (only) good described to evidence-based interventions
17:00 – 17:30	Day one wrap-up: feedback from plenary groups
	Day Two
9:00	Welcome back and lessons learned from Day One
9:30 – 10:15	Database design: 'what works' by theme and target group - *Making the best practice portal practical: how to encourage its use by intervention owners and public health practitioners (as users), intervention submitter(s) and portal info user(s) – Gerard Molleman, GGD Gelderland Zuid* - *Lessons from the evaluation of the Public Health Wales Good Practice Scheme – Alison Maassen, EuroHealthNet*
10:15 – 10:45	Cost-effectiveness of the public health and disease prevention databases www.kosteneffectivietitvanpreventie.nl. Presentation and discussion *Paul van Gils, RIVM*
10:45 – 11:30	Exploring next steps, including potential for joint (European) actions - Whether and where is an added value for cooperation, including criteria, generating evidence, quality, etc. - Areas and issues of common interest - Proposals for joint approaches
11:30 – 11:45	Publicising and cross-promoting best practice portals – How can EuroHealthNet and the European Commission help in dissemination and exchange?
11:45 – 12:00	Closing remarks *BZgA* *EuroHealthNet*
12:00	Lunch and close of workshop

3 Programme: Day One

Welcome and Introductions

Martin Dietrich, Deputy Director, BZgA

Dr Dietrich, Deputy Director at BZgA, welcomed participants to Germany and to the BZgA offices. He expressed his thanks for their participation, and noted that everyone was well-aware of the importance of health promotion portals. He noted that another commonality was the fact that we know the limits of our portals and the challenges we face to further develop them. He hoped that we would explore some common questions around evidence, evaluation and use of portals, and exchange many ideas to improve and possibly embark on new joint European approaches. He concluded by saying he was keen to see what would result from this exchange and how we can make more out of our common features.

Alison Maassen, EuroHealthNet

Ms Maassen also thanked participants for joining the workshop, and thanked BZgA for hosting and co-chairing the meeting. She noted that the EuroHealthNet Annual General Council Meeting had just been held the week before in Madrid. One of the main points discussed in Madrid was capacity building and how EuroHealthNet can do more. BZgA, RIVM and SpFrance had approached EuroHealthNet last year to organise this workshop, and it was inspiring to see how much interest and demand it generated amongst the full membership. It is clear that this is an important area in which we should collaborate and continue to build capacity. She noted that she was looking forward to the discussions around how to take advantage of the full potential of best practice portals, including addressing issues of evidence, use, maintenance and promotion.

Overview of current development of national best practice portals

France: Pierre Arwidson, Santé publique France

Dr Arwidson started by describing the normal process of implementing prevention programmes. Rather than being based on evidence, many of them are based on values. While further evaluation is needed, we know that some of them are not only ineffective but counterproductive and deleterious to the programme's stated goals. We need evidence-based programme registers as a part of our efforts to bridge the gap between 'science' and 'service.' Yet these portals represent only one part of the system that we must build. Additional challenges include effective evaluation and the dissemination and implementation of cost-effective interventions.

The French best practice portal is based on the Dutch (RIVM) portal. SpFrance and RIVM had previously met on a bilateral level to discuss best practice portals. The portal has two entrances for practices to be included. The first is through scientific literature and the second is through promising practices submitted

through an online submission form. All submissions are reviewed by a committee of independent reviewers before being included on the online portal. As of June 2019, 80 programmes had been described to date, but not yet evaluated as the evaluation grid had just been finalised. One specific best practice highlighted by Dr Arwidson was ICAPS, an effective obesity reduction programme, with a massive online open course (MOOC) available to all (in French). The link to the MOOC is available at: http://moocaps.santepubliquefrance.fr/. The French best practice portal can be accessed at the link: https://www.santepubliquefrance.fr/a-propos/services/interventions-probantes-ou-prometteuses-en-prevention-et-promotion-de-la-sante.

Dr Arwidson concluded by explaining the importance of continued monitoring of programmes and practices over time to understand how adaptations to context can make 'positive' or 'negative drift' in the effectiveness of the practice. He noted that we must focus on applied implementation (figure 1), as well as how to improve the science of intervention adaptation over time to ensure that interventions remained effective and relevant to the needs of the community.

Figure 1: Applied implementation[1]

Germany: Freia De Bock, Head of Department "Effectiveness and Efficiency of Health Education," Federal Centre for Health Education

Prof De Bock noted that there were already some differences between the French and German portals. France is continuing to refine its relatively new and current approach while Germany is considering a new approach integrating the existing good practice with best evidence in one portal. The German system started in 2001. The portal consists of a comprehensive nationwide collection of projects and interventions to promote the health of socially disadvantaged groups at the community/setting level. The portal aims to disseminate (good) practice in Germany, promote its translation into action, create transparency in terms of quality criteria and make the diversity of practice more visible. A secondary aim is to promote regional networking and the exchange of experience. To this end, an exchange platform (inforo) is also offered via the operating agency, which remains limited in use.

The portal is operated by the Association for Health Promotion Berlin, which is an agency at the practice level. In addition, the coordinating offices of Equity in Health in all federal states support networking in social situation-related health promotion at state level, accompany and advise local authorities (bundeslanden) within the framework of the partner process "Health for All", contribute to the further development of the practices and strengthen the issue of equal health opportunities. The structure consists

[1] Fixsen DL, Naoom SF, Blase KA, Friedman RM, Wallace F. Implementation research: a synthesis of the literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network; 2005.

of good practice criteria, a portal (Praxisdatenbank), the good practice database, and capacity building tools (including learning workshops and a toolbox).

The portal does not intend to identify the most effective practices, but to be a database of well-described interventions that are feasible to implement in Germany. Therefore, the evaluation process was designed as a mutual advisory process: it starts with a standardized description of project owners according to 12 good practice criteria, followed by a review by experts from the responsible local offices of Equity in Health, then a peer evaluation by another coordinating body in another federal state, and, finally, evaluation by an expert from the nationwide working group at the BZgA. Thus, the evaluation process is also set up to promote mutual learning with the goal of in turn increasing quality of the practice nationwide, with the advantage of being close to the implementation needs and the potential disadvantage of lacking objectivity.

Currently the portal includes 3067 practices, out of them 124 fulfil the good practice criteria and have been identified as such. The good practice criteria alone have been quite influential, as they are often referred to by both practitioners as well as the scientific community. This feature of the portal might increase relevance and comprehensibility of project descriptions and consequently facilitate translation into practice. The basis for inclusion in the portal is the fulfilment of 5 out of 12 good practice criteria (Figure 2), with their assessment performed by external reviewers.

Figure 2: The 12 good practice criteria of the German Best Practice Portal

Prof De Bock named the primary challenges facing the German portal as:

- How to increase use of the portals by both decision makers and practitioners
- How to increase practitioners' competence to use evidence
- How to include evidence as a main criterion
- How to integrate both needs assessment and recommendation of appropriate interventions in a single tool
- Collecting sufficient data at the local level to build a more robust database

She concluded that she looked forward to hearing from the other countries, as well, to compare and contrast their experiences.

The Netherlands: Karlijn Leenaars, the Netherlands National Institute for Public Health and the Environment

Dr Leenaars first introduced the aim of the RIVM Healthy Living Institute, which is to improve the health of all Dutch citizens. It achieves this aim through promoting a healthy lifestyle by collecting and disseminating knowledge, interventions and examples and supporting health professionals in their work with tailored advice. RIVM offers a well-established database with recognized interventions, as well as overviews of interventions for different themes and target groups. The objectives of the recognition system include providing policymakers and professionals with sound information on quality and effectiveness of available health promotion interventions, promoting the use of good-practice and evidence-based interventions at local, regional and national level, and to promote the quality of interventions through further evaluation and research.

The system collects both evidence-based practice and practice-based evidence and works to continuously link them. The collection is organised through a collaboration between seven different organisations covering sectors such as youth, mental health, disability, sports and physical activity and welfare. All of these sectors are covered under a single assessment system.

There are three categories of practices described (Figure 3): Level 1 is well-described and peer-reviewed; Level 2 is theoretically sound; and Level 3 is effective. Within the Level 3 Effective category, there are several levels, including first indication for effectiveness, good indication for effectiveness, and strong indication for effectiveness. Across all levels and categories, feasibility of implementation is a key consideration, as well. Once a practice has been recognized, its recognition is valid for three years (for 'Well-described' practices) or five years (for 'Theoretically sound' and 'Effective' practices).

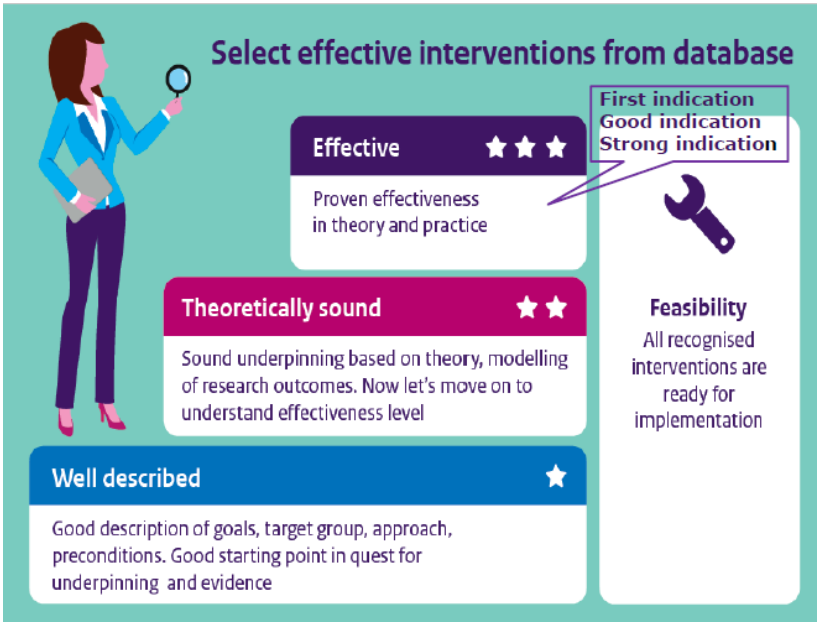


Figure 3: Categories of practices described in Dutch best practice portal

The submission form for organisations is standardized and uses the same format across all levels. The minimum requirement for a practice to be submitted includes a process evaluation, a manual and proof of ownership. It often takes between 20-60 hours for an organisation to complete the form, with both

feedback and the opportunity for a workshop from RIVM. Organisations are motivated to complete the form because it is tied to government funding. If the rest of the countries are interested in the RIVM criteria, RIVM is willing to share them with the group. The submission requirements include description of the intervention, preconditions for implementation and quality assurance, theoretical foundation (required for 'theoretically sound' and 'effective' categories), and effectiveness (based on Dutch and international studies). Within the Level 3 'Effective' category, an intervention has 'first indication' of effectiveness if it has a pre-post study design including monitoring. It reaches 'Good' effectiveness when it a controlled study design has been implemented, and 'Strong' effectiveness when a controlled study design has been implemented and followed-up at six months. The results database in May 2019 showed 317 total interventions in the database, including 34% 'Well-described,' 46% 'Theoretically sound,' and 20% 'Effective' across the three levels of indication.

It was noted that participants would hear more about the Dutch example in the afternoon when Dr van Dale presented on implementation.

Slovenia: Sandra Radoš-Krnel, The National Institute of Public Health of Slovenia

Dr Radoš-Krnel presented on behalf of NIJZ. She noted that there were many different preventive programmes and health promotion interventions in Slovenia, but few are well-described and evaluated for their effectiveness.

The purpose of the Slovenian platform, currently under development, will be to gain better insight into the quality and effectiveness of interventions for health promotion and preventive programmes, as well as to improve design and implementation expertise, particularly when targeting certain populations or disadvantaged groups. They would also like the platform to enable better use of financial resources, particularly projects and programmes within the various tenders financed by the Ministry of Health. The objectives also include providing a pool of reviewed interventions, creating guidelines for designing and planning implementations, supporting networking and interdisciplinary collaboration, and improving the overview of health promotion and disease prevention efforts.

The organisational structure is composed of a steering committee, an advisory group and a workgroup. The Steering Committee is tasked with reviewing and confirming the proposed methodological and substantive approaches, providing guidance, and ensuring integration between key institutions. It will be made up of representatives at high level from various types of organisations (ministries, universities, NGOs) who can be promoters within their organisations. The Advisory Group is responsible technical implementation overall, including: establishing the criteria to assess good practices, defining 'good' practices, preparing a questionnaire to collect practices, guidelines for evaluating practices, supervising this submission process as a whole, and preparing recommendations for an online portal/platform to host the collected practices. The Workgroup is specifically responsible for collecting, reviewing and evaluating practices in collaboration with experts.

To date, there has been a review of existing criteria and platforms. NIJZ worked with RIVM on the Reducing Alcohol-Related Harm (RARHA) project, which was one of the inspirations to begin work on a national platform in Slovenia. They have also reviewed the best practices collected by other Joint Actions (JANPA,

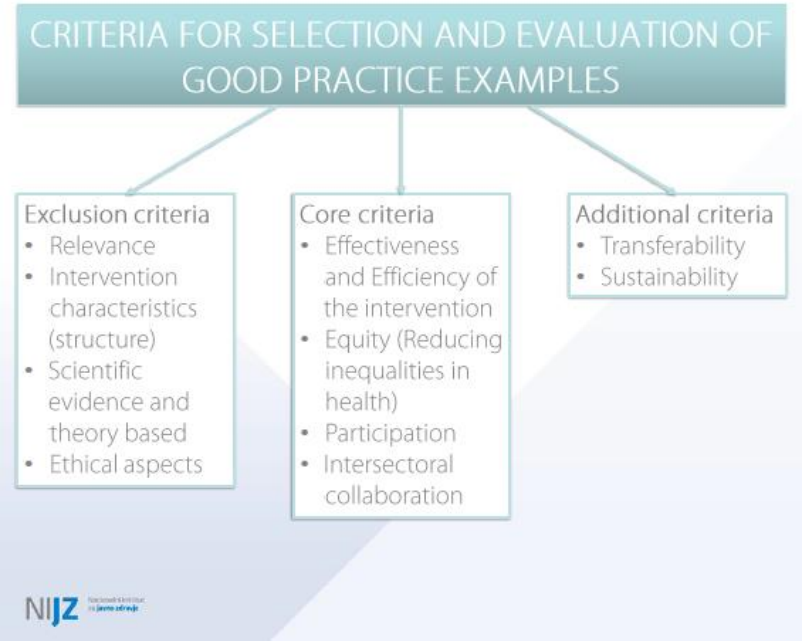


Figure 4: Criteria for selection and evaluation of good practice examples in Slovenia

CHRODIS) and portals (EMCDDA, European Best Practice Portal) to study their criteria and guidelines and submission processes. At this point, the Advisory Group has established the criteria for assessment and defined 'good' practices. They selected the same criteria used by the European Best Practice Portal, which served the dual purpose of allowing practices to be submitted to both the national and European level in a streamlined way (Figure 4). Dr Radoš-Krnel noted that the sub-criteria were distinct, however, as they did not have sufficiently robust data collection systems in place. The Advisory Board is currently preparing the questionnaire for collecting good practices and preparing the guidelines for evaluating the practices. They will pilot test the portal in the field of preventing/reducing alcohol-related harm. One important consideration for them will be how to make the assessment beneficial to the individuals and organisations submitting practices to the portal, and how NIJZ can support implementers in using the portal (e.g. workshops).

Italy: Paola Ragazzoni, Dors, Health Promotion Documentation Centre, Piedmont Region

Dr Ragazzoni presented on behalf of the Piedmont Region, whose best practice portal became a national tool in 2012. She described the portal as "Opening the black box of the intervention: how does it work? Or whom? In what context?" The Italian Good Practices Evaluation System collects more than just health promotion and disease prevention practice-based interventions and evidence. It also collects declarations and policies with impacts on public health, though this work is at an earlier stage and has not yet been assessed.

Dr Ragazzoni described the structure of the Good Practices Evaluation System. The database, ProSa, contains more than 2600 uploaded projects. It is a free database to collect, analyse and share projects, interventions, policies and good practices in order to support professionals, decision-makers and stakeholders' decision-making in the field of health promotion and disease prevention. All submitted projects can be downloaded from the portal by interested users. Submissions can be made directly to the portal for evaluation against the Good Practice Methodological Guide. The evaluation process consists of two independent reviewers who are trained and work on a volunteer basis (it was noted that this does lead to important questions regarding system capacity). Figure 5 on the following page illustrates the review process. The highest possible score is 1.00, and anything which scores below 0.39 is considered to be

insufficiently described for inclusion in the portal and submitters are provided with suggestions for improvement should they wish to resubmit.

Once a practice has been successfully added to the database, dissemination of the good practice is achieved through developing a summary document describing the practice, a newsletter article sent to subscribers, and a letter addressed to relevant policymakers describing the practice and how it could support their policy goals.

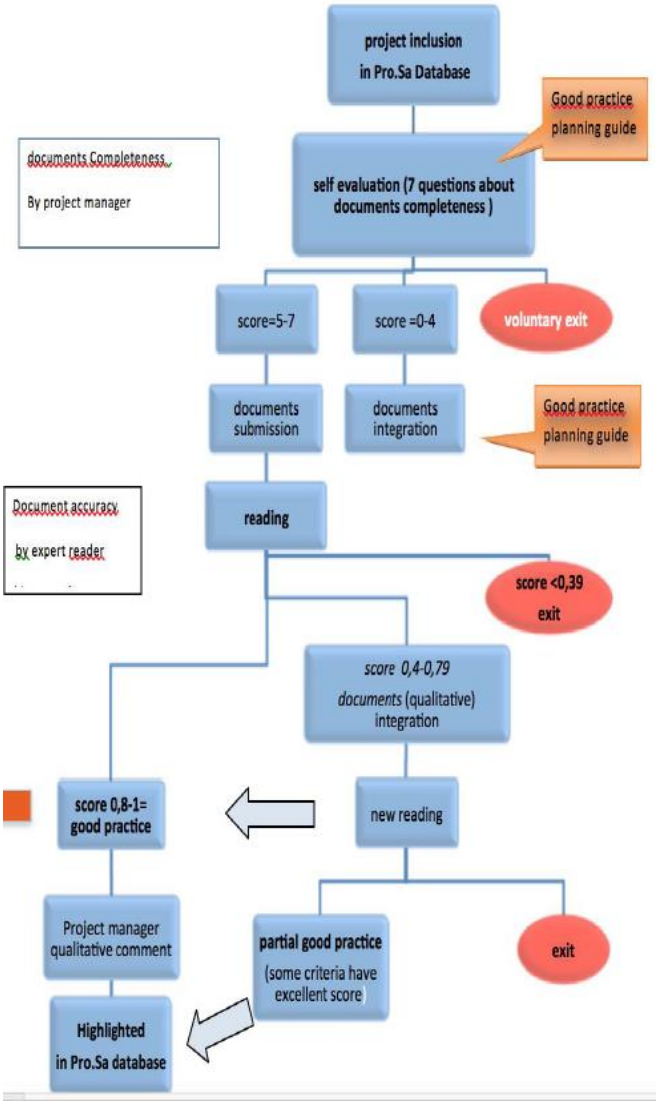


Figure 5: Evaluation flowchart in the Italian Good Practice Evaluation System

The criteria of the Good Practice Evaluation system include 18 criteria and a set of 69 questions tied to each of those criteria. The Evaluation system was first established in 2004-2005 and has gone through a number of iterations over the years. Since 2011, there have been 20 good practices evaluated and scored and 22 practices remain in-progress.

Dr Ragazzoni noted that their criteria and evaluation system are undergoing a review. This is due to new suggestions and inputs received from Joint Actions (e.g., CHRODIS, CHRODIS+, JANPA), due to the criteria adopted by the European Commission's Steering Group for Health Promotion and Disease Prevent, as well as due to comments received during training courses with Italian professionals using the current system. They are having a European online review during this year, which could be interesting to tie to the broader outcomes of this workshop. One of the new areas that will be added to the system, for instance, is a review of any ethical issues, which was not an evaluated component until now.

Q&A and Discussion on National Best Practice Portals

Dr Shanjanian-Zarneh, co-moderating the session, thanked the participants for the informative presentations which highlighted both similarities and differences in the portals across Europe, both in their

overall structure as well as in their current states of development/redevelopment. Broadly speaking, it was seen that three of the portals: Germany, Slovenia and Italy, used structures inspired by participation in Joint Actions like CHRODIS. The Dutch portal, however, which inspired the French portal, was distinct in design.

Having now seen what the portals are like, the question of how the portals could be used to better link policy to practice. French participants suggested that "Prevention should be treated like medical treatment," such that any planned health promotion interventions must be evidence-based, not values-based and required to meet certain criteria before their piloting and wider implementation in communities (citing a recent publication from Dr Fabrizio Faggiano which suggested that public health agencies should have an approvals system equivalent to those used by medical regulations agencies). It was suggested that there could be more usage of quasi-experimental designs and participants noted that there were a number of promising research designs available for testing. In Germany, in particular, the 2015 Prevention Law creates an advantage but also a challenge for health promotion portals, as it puts more emphasis on health promotion, but also on evidence and data collection. Dutch participants noted that it was important to beyond a medicalised approach, which would not be able to collect sufficient information. In the Dutch settings, they are thinking more and more about how to utilise qualitative designs. The reason for this is that they find that they currently have limited interventions available for vulnerable groups as these interventions don't generate a sufficient amount of quantitative evidence, subsequently meaning that the best practices are not included in the portal and funded. A mixed-methods approach is key, as it will also help identify potential issues with implementation. As an illustration, they described an intervention for diabetes which had been proven effective with a randomised controlled trial (RCT), but which was not effective when implemented in the community. Overall, the link with welfare is critical, especially for addressing changes in behaviour. It requires bringing insurance companies on-board, however, and challenging the dominance of RCTs. While RCTs are 'the gold standard' because they demonstrate causality, it is true that complex interventions struggle to implement RCTs. The Slovenian participant indicated that in Slovenia they are currently bringing in participants from other social sectors to discuss what other designs could be used beyond RCTs.

German participants asked the group how they were considering 'evidence' in their portals. Evidence of effectiveness is perhaps too small a scope and it should be supplemented with evidence from qualitative reports, forming a systematic synthesis of what is known about the practice. Ms Maassen, co-moderating the discussion from EuroHealthNet, also noted that the wider membership was discussing exactly these issues of evidence during the General Council meeting the week before in Madrid. The REJUVENATE framework, agreed by the EuroHealthNet membership in 2016, was under debate as it was proposed to change one of the letters – 'Ethical' (closely tied to existing letter 'Value-driven') – to stand for 'Evidence-based.' The ensuing discussion amongst members indicated that there was no clear standard for what constituted 'evidence-based' or 'evidence-informed' amongst members. It is an issue that affects much more than these practice portals, but the whole of the public health practice space.

Presentation of the Best Practices Portal of the Steering Group on Health Promotion and Disease Prevention of the European Commission. How are the programmes and practices assessed? What is the submission and selection process?

Ingrid Keller, European Commission

Ingrid Keller, from the Directorate General for Health and Food Safety (DG SANTE), presented the European Commission's Best Practices Portal of the Steering Group on Health Promotion and Disease Prevention. The portal can be accessed at https://webgate.ec.europa.eu/dyna/bp-portal/. She began by noting that the Commission and the Steering Group on Health Promotion and Disease Prevention, comprised of senior officials from Ministries of Health in the EU Member States, have also been having similar debates about evidence on the European Best Practice Portal and haven't yet found a 'silver bullet,' either. Yet she did note, however, that the portal had to have quite stringent criteria on 'best' practices since practices selected as "best" could be selected by Member States for country-to-country transfer that could be supported financially from EU funds.

The Commission's work on best practice portals was briefly put into a broader and historical context. Ms Keller noted that the European Commission's founding treaty notes that the Commission may promote "the organisation of exchange of best practice" and the United Nations High-Level Meeting on Non-Communicable Diseases declaration also includes implementation of "evidence-based interventions" and "good practices" as a recommendation. In 2016, there were six joint actions and projects that were coming to a close, including CHRODIS, RARHA, Scirocco, and VulnerABLE. Participants in these projects were looking for a way to maintain their good/best practices databases and so the Commission agreed to establish one system to house practices from the six projects. It was a practical solution and a step towards improving the sustainability of these projects' work. The database was subsequently opened so that stakeholders can also input information. The Commission maintains a system to evaluate submitted practices. Only those practices that meet the criteria are published on the portal.

The objectives of the portal include selecting best practices from across health programme actions and EU member states, and supporting member states with pre-filtered information. This can be on common priority health topics (as agreed by the Steering Group) with the view to country-to-country transfer of best practices, supported by targeted EU funding. Critically, the portal also seeks to "break the circle of exchanging and then going home to do the status quo." The portal is meant to encourage and support not only exchange but implementation of best practices in new settings.

Ms Keller described the three main features of the Best Practice Portal. They consist of:

1. Consulting existing good practices
   Visitors are able to access the database of existing best practices, which is searchable through a variety of search criteria organised by category (e.g. area/topic of interest, type of practice, year of selection). They then receive a list of corresponding practices and can click on each for a more detailed summary. One of the primary challenges with this database is maintaining up-to-date information. It is possible that some of the profiled practices, for instance, are no longer functioning. Yet there is limited staff capacity to conduct a routine check of existing practices.

2. Submitting practices for evaluation

   The portal is open both for unsolicited submissions throughout the year – evaluated on an annual basis – and also holds calls for submissions on topics selected by the Steering Group/suggested by the member state holding the periodic EU Presidency. The calls have proven very popular, as indicated by the spikes in website traffic during call periods. Submission consists of completing a 16-item online questionnaire and attaching supporting documents. The mandatory attachments are a detailed description of the practice and an evaluation report. Optional documents are related to ethics and transferability. A submitter's guide and helpdesk are in place to increase submissions and to help participants who need support e.g., in describing their methodology or indicators used, etc.

   The evaluation process is managed by the Commission's Joint Research Centre (JRC). There are three evaluators per practice, including one rapporteur who writes the consensus report. The evaluation criteria were adapted from the criteria used by Health Programme projects and actions such as CHRODIS and RARHA. An Evaluation Committee, composed of European Commission staff, then discusses the outcome of the evaluation by experts (with a focus on "difficult cases") and agrees which practices can be considered as "best" practices. Any practices not selected in this process are offered suggestions for improvement.

   Ms Keller noted that there are several challenges around submission and evaluation. One of these challenges relates to the calls for proposals. While they receive higher traffic during call periods, this does not always convert into more submissions. They would like to know why some visitors conclude that they do not want to submit. Another challenge they are looking into is the submission of best practices with commercial interests and how to best address this. Finally, while a consensus evaluation report is provided for every practice, the level of detail and constructiveness of the report varies.

3. Consulting projects and tools regarding best practice transfer

   This is a new element of the portal which remains under construction. The Commission is currently working on best practice transfer guidance documents, notably through the CHRODIS+ Joint Action that transfers previously identified good practices like "Active School Flag" and "Toybox" to other countries. They are also supporting the transfer across different settings/Member States through the activities of the Steering Group. The group – representing Member States – selects a topic annually. In 2018, for instance, it was nutrition and physical activity, while in 2019 it was mental health. The selected best practices are presented to the Steering Group and each Member State selects which best practice they would like to transfer and scale-up through a "marketplace." In addition, the Commissioner organised a certificate-award ceremony in June 2019 where recently approved best practices received a Certificate of Recognition. A video that documents the marketplace on nutrition and physical activity can be accessed at:

   https://ec.europa.eu/health/non_communicable_diseases/events/ev_20180315_en

Ms Keller ended by thanking the participants for their attention and encouraging them to visit the Commission's Best Practice Portal website.

During the discussion the question was raised about the coexistence of several portals : national ones on the one hand, the EC best practice portal, the recently launched knowledge action portal launched by WHO

2, how differences about the content and aim of those portals could be explained to users, and how to develop relationships between the national portals and the EC best practice portal. These were further discussed later in the afternoon.

Assessment criteria for evaluating and identifying suitable interventions for health promotion best practices.

The Current State and Challenges of Prevention Registries

Karl G. Hill, Blueprints for Healthy Youth Development, University of Colorado Boulder

Prof Karl G. Hill, the Director of the Prevention Science Program and Principle Investigator for Blueprints for Healthy Youth Development at the University of Colorado Boulder, was an invited expert speaker for this workshop. He gave a presentation describing the Blueprints Registry, its current and future challenges, and some suggested solutions.

Blueprints for Healthy Youth Development is a web-based registry of experimentally proven programmes (EPPs) promoting the most rigorous scientific standard and review process for certification. Blueprints can be accessed at www.BlueprintsPrograms.org. The goal is to provide communities with a trusted guide to interventions that work. Prof Hill encouraged participants to "know their audience" and who uses their registry/portal and for what purpose. Blueprints receives 1400 unique visitors per day who are primarily policymakers, education professionals, and other government and/or community officials. The portal interface should accordingly be designed to make it appealing to the users, including easy access to the elements of the portal that might be most interesting to each type of visitor.

Blueprints began in 1986 with a focus on youth programmes to prevent violence, crime and drug use. At the time, ineffective programmes were (and, in some cases, remain) very popular. In 2010, it was expanded to include academic success, emotional and physical health and positive relationships. It expanded once again in 2016 to include a focus on adult prevention programmes, practices, and policies, as well. Since 1996, the registry has expanded from 10 programmes to 1544 reviewed programmes, including 89 certified programmes. Of the certified programmes, three are considered 'Model Plus' Programmes which have very strong research evidence of sustained effect and which are ready to be scaled into communities. 14 'Model' programmes offer strong research evidence of sustained effect and are also ready to go. 72 additional programmes have been recognized as 'Promising Programs' which have moderate research evidence and which are suggested for further testing. In total, 6% of all programmes reviewed by Blueprints have been certified as either "Promising," "Model" or "Model+" programmes. Figure 6 below illustrates the Blueprints Classification Framework Criteria.

[2] https://www.knowledge-action-portal.com/

	Evaluation Design	Significant Effect	Sustained Effect	Successful Replication	Research Design Issues
Model Plus	2 Randomized Controlled Trials (RCT), or 1 RCT and 1 Quasi-Experimental Design (QED)	Blueprint behavioral outcome $p < .05$	Yes	Independent replication in 1 study	Satisfies all
Model	1 RCT and 1 Replication (RCT or QED)	Blueprint behavioral outcome $p < .05$	Yes	1 RCT or 1 QED	Satisfies all
Promising	1 RCT, or 2 QEDs	Blueprint behavioral outcome $p < .05$	No	No	Satisfies all
Ineffective	1 RCT or 2 QEDs	Blueprint behavioral outcome with Null effects	No	No	Satisfies most
Harmful	1 RCT or 2 QEDs	Blueprint behavioral outcome with significant harmful effects	No	No	Satisfies most
Inconclusive Evidence	RCTs or QEDs	contradictory or weak findings; evidence can't be fully supported by design; only 1 quality QED	No	No	Some methodological problems
Insufficient Evidence	Major design flaw No control group No Evaluation	Design too weak to support findings; or no evaluation or control group	No	No	Flawed experimental design or non-experimental design

Figure 6: Blueprints Classification Framework Criteria

Of the non-certified submissions, 80% of the reviewed programmes have design and/or analysis problems, including 0.3% which were found to be harmful. 11.5% were still in the process of being reviewed.

Prof Hill proceeded to discuss current and future challenges facing Blueprints and other registries, as well as some proposed solutions. The first challenge addressed was the limited use of registries by policymakers and agency staff, who do not tend to use evidence-based registries to make decisions. To make the registries more attractive, they need to respond to the desires of key decision makers. They want to see, for instance, information on the full set of available programmes, not just those that are certified. They also want more information on the programme as a whole, not just impact (e.g. implementation experience, start-up costs, resource needs). They want guidance in selecting programmes and planning for implementation, as well as information on policies and best practices. Finally, the registry should have user-friendly navigation and a readily-understood ratings system. In response to these desires, the Blueprints registry was updated and adapted. For instance, all 1544 programmes, practices and policies in the Blueprints database – both certified and non-certified – are rated on a continuum of evidence classification and are now on the website. Dr Hill stressed that certified and non-certified interventions are not presented on the same list, however, and are found on completely different parts of the website to avoid any confusion. They have also expanded the information available on each programme, practice and policy to facilitate better-informed decision making. Each certified intervention now comes with a factsheet that includes comprehensive information on the intervention (Figure 7).

Figure 7: Screenshot of a section of a factsheet for a Blueprints Model+ Intervention

The second major challenge Prof Hill described was the abundance of registries and their different standards of evidence, which result in inconsistent ratings across registries. He noted that, in the United States at least, there was an ever-changing landscape of registries whose existence was usually subject to funding opportunities. In 2015, the Bridgespan Report reviewed 35 US registries. Now there are even 'clearinghouses of clearinghouses,' or registries that track registries.

Across these various registries, there are serious discrepancies in the total numbers of interventions listed (some as many as 700, others as few as 90), and their standards of evidence were highly-variable, such that the same intervention would score very differently across different registries. Part of the reason that these ratings may vary is that the developmental mechanisms targeted by the intervention's logic model are not the same in different cultures. For instance, many interventions have been developed and tested in one population may now be implemented in a different population. In this case, should we assume that the intervention will not work without adaptation? Or, conversely, should it be implemented exactly as designed in the new community with high fidelity? A 2016 study conducted by Frances Gardner and colleagues investigated this matter,[3] looking at 17 studies that transported four parenting interventions

[3] Gardner, Frances (2017). Parenting Interventions: How well do they transport from one country to another?, Innocenti Research Briefs no. 2017_10, UNICEF Office of Research - Innocenti, Florence

designed in the US and Australia to new country contexts (including Canada, Iran, Puerto Rico, Holland, and Hong Kong). Contrary to popular belief, the study's results found that extensive adaptation did not appear necessary for successful transportation of parenting interventions. Rather, what they proposed was inhibiting or enabling effectiveness may have been the quality of the implementation and evaluation processes.

Registries have different standards and review processes. For instance, they may consider various measures (e.g. RCTs vs quasi-experimental designs, evidence of sustained effect, evidence of replication), and they place varying importance on each measure. Prof Hill's suggestions to address these challenges included considering NOT creating another registry but instead joining a different registry. He also said there was a need for better coordination across the major registries, particularly in their design, analysis and reporting standards and in their ratings and recommendations. For the time being, what Blueprints does to address this is to include information on different 'endorsements' an intervention has received from other major registries (Figure 8). This helps users to quickly compare and contrast across other registries with which they may be familiar.

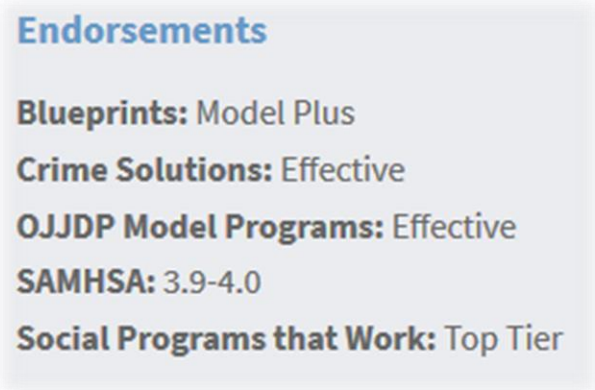


Figure 8: Blueprints' endorsement section allows users to compare an intervention's rating across major registries (in the US)

Another important challenge Prof Hill raised was confusion over the term "evidence-based." The original meaning of the term required experimental evidence from rigorous trials demonstrating evidence of a causal relationship. Yet today "evidence-based" is used to refer to a continuum of evidence in which even weak evidence can justify considering an intervention "evidence-based." While policymakers usually assume that any "evidence-based" intervention is better than doing nothing, Dr Hill argued that this is not necessarily true. There are ethical concerns around implementing an intervention with unknown (and potentially harmful) effects. Prof Hill suggested that the term "evidence-based" be replaced with "experimentally proven" for programmes/practices certified as having demonstrated effectiveness.

As the Blueprints registry includes programmes, practices and policies, Prof Hill took a moment to elucidate the differences, as far as how they are defined by Blueprints. "Programmes" are discrete interventions, often covered by intellectual property laws, with a logic model, training curriculum, manual and so forth. "Practices" are generic strategies with no single owner that have proven effective, on average, in systematic reviews (e.g. cognitive behaviour therapy). "Policies" include regulations or statutes enacted to prevent outcomes across a large population. They are usually proven effective in QEDs which compare outcomes before and after the policy's enactment.

The final major challenge Prof Hill described was how to determine certification status in the face of mixed evidence. Over time, experimental evaluations of interventions often return mixed results, with some attempted replications supporting the intervention's efficacy and others not. This results in the need to establish a "predominate effect" for an intervention. Towards this goal, Blueprints is exploring the use of meta-analysis to determine if, on balance across attempted replications, there is evidence of efficacy. While

for a specific programme with clear criteria for implementation, this seems more feasible, it is very difficult to do for practices and policies with no established guidelines for implementation. There is a need to further develop standards of evidence for interventions with mixed results.

Finally, Prof Hill presented Communities that Care (CTC), a strategy to guide communities through the steps of science-based prevention. The model can be found at www.communitiesthatcare.net. The process consists of five phases. The first is "Get started," in which communities prepare to introduce the CTC model. This requires activating a small group of catalysts and identifying key community leaders, as well as inviting diverse stakeholder engagement. The second, "Get organised," requires communities to form a board or work within an existing coalition to write a vision statement and learn about prevention science, and develop a timeline for implementation. The third, "Develop a community profile" requires the community to assess their risks and strengths and identify existing resources. The fourth step is "Create a community action plan" by selecting effective policies and programmes from the Blueprints website and defining clear measurable outcomes. In the final phase, "Implement and evaluate," community members implement, monitor, evaluate and measure their selected programmes and policies to track progress and ensure that improvements are achieved. This CTC model is currently being successfully implemented in in over 130 communities in the US and dozens of communities around the world, including Germany, Sweden, Denmark, The Netherlands, the United Kingdom, Croatia, Austria, Switzerland, Canada, Mexico, Colombia, Chile, Panama and Australia.

Prof Hill reiterated that participants should email him if they would like to receive copies of any of the Blueprints materials. He would be happy to share their checklists and other evaluation materials with the group.

How to assess the evidence base?

Freia De Bock, BZgA

Prof De Bock presented on assessing the evidence base for health promotion and disease prevention registries. She noted that, as Dr Hill had said, there are many different definitions of "evidence-based" and what makes something a "best practice."

She shared the principles of evidence-based prevention and health promotion (STIIP). They are:

1. Systematic search, rating and summary of scientific knowledge
2. Transparency of decision-making process
3. Participation and integration of practice experience and values
4. Declaration of conflicts of interest
5. Structured reflection process

For measuring and assessing standards of evidence for interventions, there are three points to be taken into consideration: efficacy, effectiveness, and readiness for dissemination. To measure efficacy, the following should be considered: is the intervention well-described with a logic model, and measured outcomes? Has the intervention been studied with a study design allowing causal inference (e.g. RCT, interrupted time series)? To measure effectiveness it would help to review and consider the real-world conditions under which the intervention is thought to be effective, as well as measurement of acceptance, adherence and participation in the targeted population. Finally, readiness for dissemination should look at

whether or not there is training and support available for intervention replication and scale-up, necessary monitoring and evaluation tools, and available cost-information.

Prof De Bock also raised a question about systematic searches for projects. She asked participants whether or not they felt that we were missing important solutions by waiting for people to submit projects to the databases rather than going out and proactively finding and assessing existing practices. She also asked about conducting systematic monitoring of programmes. French participants indicated that they had one programme that was doing a structured monitoring process, and it was noted that there was also a successful structured monitoring process for a specific programme in the US. It would be very challenging to conduct systematic monitoring could be done across various programmes simultaneously, however.

There were additional questions raised around how to construct the ideal evidence-based database, including questions about how the results of systematic reviews can be added into databases, how to systematically include practitioners in the process, and how to include evidence on other research questions (e.g. social aspects such as inequalities, environment) beyond effectiveness. Prof DeBock thanked participants for their attention and their consideration of these important questions.

What Works Centres for evidence-based policies in France

Ben Rickey, ANSA (the New Agency for Active Solidarities)

Mr Rickey, another invited external expert, from the *Agence nouvelle des solidarités actives* (ANSA) presented lessons from the UK What Works Centres and their impact on current activities in France. Ansa is a "think and do tank" with around 30 projects per year in the fields of poverty and social exclusion. They work with national and local authorities, charities and foundations, private companies, the European Commission, and people with "lived experience." Their missions include running trials, advising, and disseminating their findings.

The starting point for their work was a review of social experimentation in 2014 (*Expérimentation sociale à l'épreuve du terrain en 2014).* It consisted of a partnership between six French public agencies with common concern that evidence rarely influenced public policy and practice. They had a desire to learn from the British What Works Centres to develop similar initiatives in France. The project included a report drawing lessons from the What Works Centres for France, and scoping notes for French What Works Centres in five fields.

The British What Works Centres, in turn, were inspired by the National institute for Health and Clinical Excellence (NICE), established in 1999. NICE has become a pioneer in evidence-based health policy thanks to its robust methods and its impact on medical practice. Leading figures in social policy championed efforts to extend the type of work NICE conducts into the area of social policy, noting that there was an absence of organisations responsible for connecting the supply of 'evidence' with demand. At the time this was happening, 2011-2012, it coincided well with the interests of political leadership, and support from influential policymakers. The idea was therefore incorporated into a public service reform strategy and a team dedicated to create these new centres for social policy was established in the Cabinet Office.

British What Works Centres (WWC) were a response to a simple observation: a significant proportion of British public services are not, or only to a limited extent, "evidence-based". They were therefore set up to promote the adoption of interventions that "work." They are primarily small, independent organisations

housed within a charitable organisation, foundation or university. Nine are thematic and two are territorial, and they each manage an annual budget between £500,000 – £14 million. They are very close to the public agencies as they benefit from public funding for their operation. A list of current WWC is found in Figure 9.

What Works Centres : from health to social and economic policy, a growing network

Structure	Founded	Statute	Team
National Institute for Health and Care Excellence (NICE)	1999	Public	~600
Education Endowment Foundation	2011	Charity	19
Early Intervention Foundation	2013	Charity	16
What Works Centre for Local Economic Growth	2013	Consortium	10
What Works Centre for Crime Reduction	2013	Public	-
Public Policy Institute for Wales	2014	Consortium of universities	8
What Works Centre for Scotland	2014	Consortium of universities	7
What Works Centre for Wellbeing	2014	Social enterprise	8
What Works Centre for Ageing Better	2015	Charity	17
Centre for Homelessness Impact	2019	Charity	7
What Works Centre for Children's Social Care	2019	Incubated by Alliance for Useful Evidence	1

Agence nouvelle des solidarités actives

Figure 9: The current network of British What Works Centres

Despite their varying thematic foci, all WWC conduct the following activities:

- Synthesising existing research in their policy area(s), translating research for professionals and policymakers
- Disseminating and supporting adoption of evidence-based innovations, particularly through "toolkits", events, training and other communications activities
- Prioritise changing frontline practices (a bottom-up approach) rather than influencing the national public policy agenda. They consequently primarily focus on regional and local decision-makers
- Prioritise research into effective solutions rather than needs analysis. This is done through ranking programmes according to their effectiveness and providing an indication of the costs of various programmes to inform decision-makers' choices.

Mr Rickey went on to describe the methodology used by the WWCs to collect and evaluate evidence, as illustrated in Figure 10. The centres conduct extensive systematic reviews over three-year periods and use the "systematic review" method to avoid the inherent bias in traditional literature reviews.

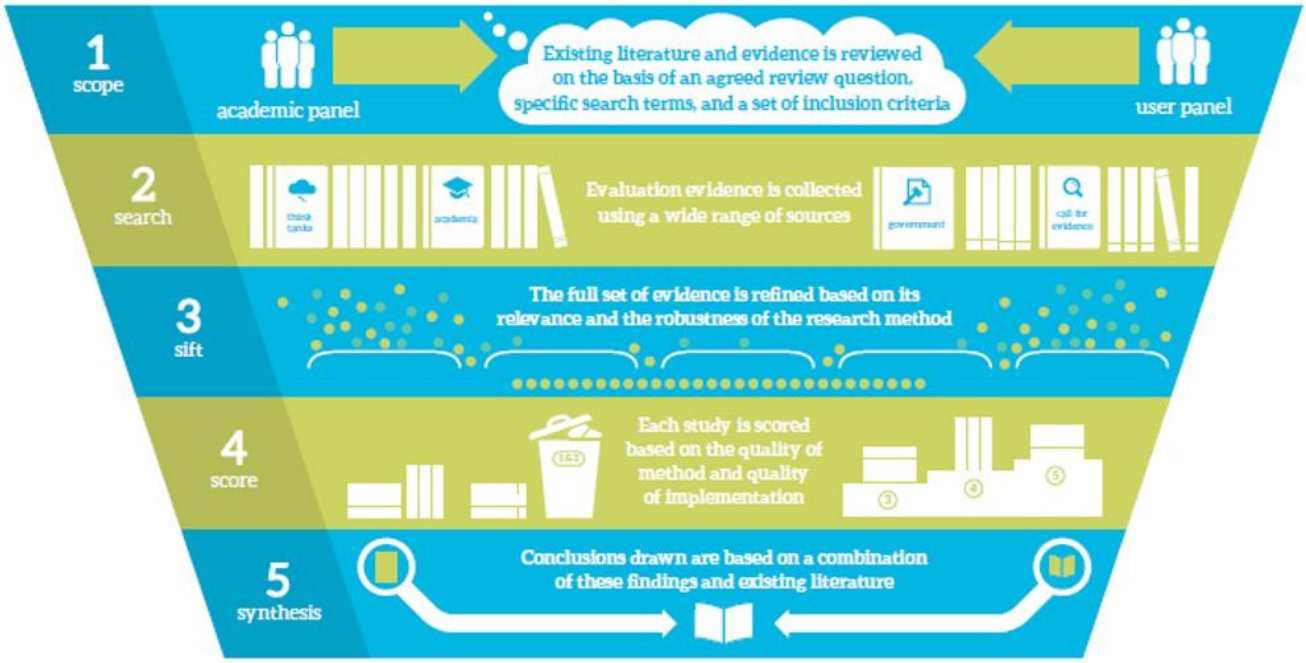


Figure 10: Systematic review methodology

WWCs consider that there are many forms of evidence and they focus on the evidence of the impact of policies or interventions. They also focus on effects at local level rather than large-scale policy levers. Types of evidence may describe a societal phenomenon (e.g. cross-sectional or longitudinal surveys), understand lived experiences and social processes (e.g. ethnographic methods, focus groups), or seek to establish a causal link between policy/intervention and impact (e.g. experimental studies, quasi-experimental studies). Many WWCs have been inspired by Nesta, a UK charity, and its standards of evidence, which place levels of evidence on a 5-point scale.[4]

In order to attract local decision-makers and policymakers to their work, many WWCs have developed "toolkits" or registers of their interventions. The Teaching & Learning Toolkit (Figure 11), for instance, is a review of reviews of research into the effectiveness of various educational interventions. The toolkit allows users to quickly analyse various interventions based on three aspects:

- Cost: an estimate of the annual per-pupil cost of the intervention was carried out in classes of 25 pupils, and typically including costs of teacher training and materials;
- Evidence strength: a measurement of the quality and quantity of studies carried out, with a focus on evaluations with a control/comparison group;
- Impact: for this particular toolkit, on education, researchers have translated the size of effects observed during the interventions into a measure of additional months of educational progress for beneficiaries (in contrast to a counterfactual).

4 https://www.nesta.org.uk/report/nesta-standards-of-evidence/

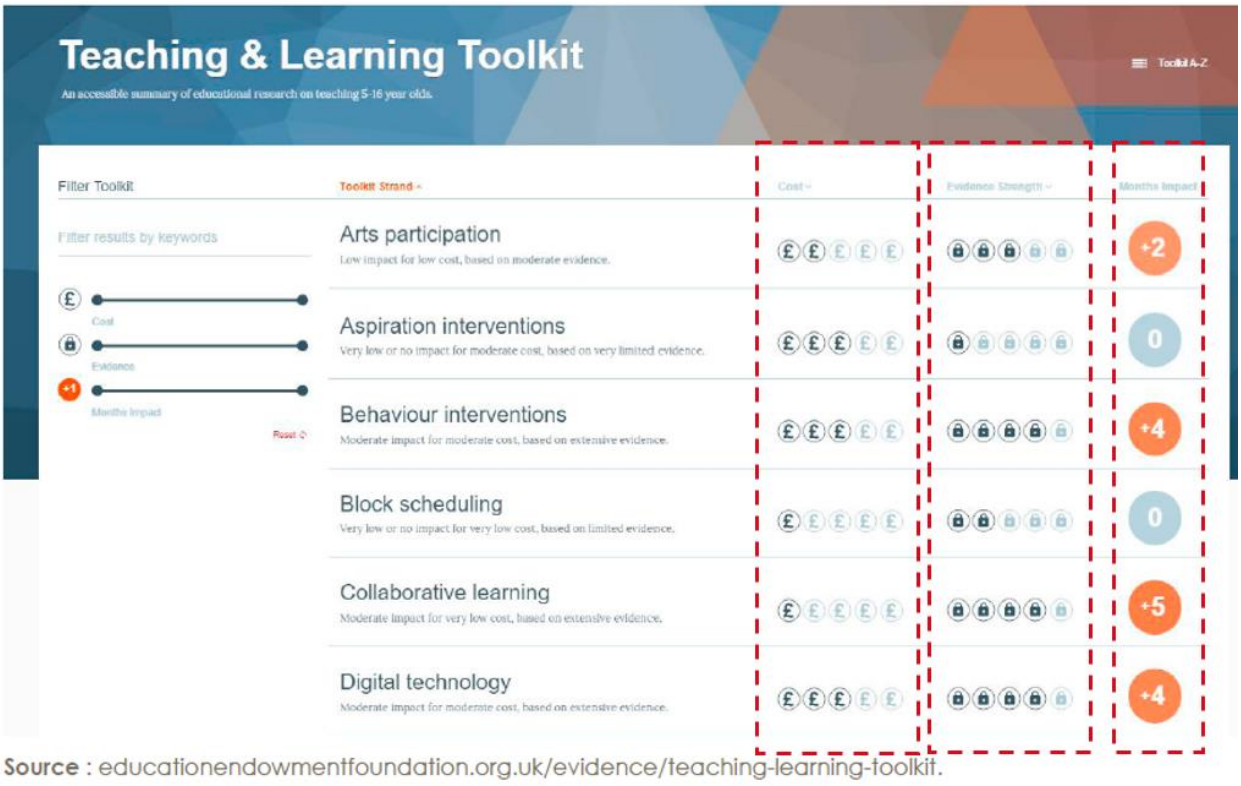


Figure 11: Teaching & Learning Toolkit comparison of various educational interventions

In comparison with traditional ways of presenting research results (e.g. academic journals), which have less outreach to decision-makers, a 2015 survey by the National Audit Office found that around 64% of head teachers used the Teaching & Learning Toolkit to inform their decisions around pedagogical practice.

Mr Rickey then explained how all of the WWCs activities are influencing evidence-based policy making in France. The key lessons that the French have drawn are:

- Creating “one-stop shops” for evidence on “what works” for practitioners seems to be a promising approach, as it allows practitioners to quickly access advice that is both clear and evidence-based. It also ties practitioners more closely with the research, such that they help shape outputs and apply the research in practice.
- Production of systematic reviews is often challenging due to lack of high-quality evidence and the complex mechanisms and contexts through which and in which interventions are tested.
- Supporting the adoption of evidence-based interventions remains a challenge, in spite of promising new approaches to dissemination, and it would be worth further developing and improving approaches for transferability and adoption of evidence-based interventions.
- Financial support for testing interventions has been a real asset, as it brings them closer to practitioners in a critical phase of their development
- Evidence base should not be seen as static, but continually updated.

While France has a long history of public policy evaluation starting in the 1960s, it wasn’t until around 2007 that an increase of experimental methods were used and a real cultural shift towards “trial infrastructure” and an “experimental reflex” occurred. Now there are more and more knowledge transfer initiatives, but only a handful comparable to the WWCs. They include the Health Authority (Haut Autorité de Santé), the

Intervention library profiled by Dr Arwidson (Santé Publique France), the French Education Institute (CNESCO), and the Youth Experimentation Fund. In sum, What Works France is a nascent movement!

Translating best practice interventions into implementation: addressing the scalability, replicability and other aspects of transferability, and practical concerns of applying the knowledge and improving implementation: Presentation and discussion

Djoeke van Dale, RIVM

Dr Dale gave a presentation further elaborating on lessons from the RIVM best practice portal, focusing on the translation of best practice interventions into implementation.

She presented results from Dutch evaluation studies on the implementation of best practices conducted in 2013 and 2018. The approximately 600 respondents, primarily practitioners, indicated that they appreciated the best practice system, which gives insight into the quality, effectiveness, and feasibility of using selected interventions. She noted that professionals will choose to use a best practice if:

- Management supports the use of the selected best practice (or best practices, more broadly)
- The government provides incentives to use best practices, and/or
- Municipalities demand the use of best practices
- If the selected best practices are easy to implement and low-cost.

Professionals will select not to use best practices if:

- They are unfamiliar with the database and the different levels of evidence
- If they feel that the best practices cannot be adjusted to the local context
- If they want to align with the existing activities in the municipality and/or organisation; or
- If they are missing information on how to choose and adapt an intervention

RIVM has several strategies to improve the uptake of best practices. The first is a dissemination strategy which uses more visuals, more stories and more alignment with other programmes. They specifically produce newsletters and an e-magazine for policymakers, recruit champions on a local level, and have increased their presence on social media and the number of stories and visuals they produce.

Dutch strategies also include incentive strategies from the Ministry of Health and the Research institute. There is budget available for implementation of best practices in schools and municipalities related to lifestyle, sports, and health promotion. On the research side, recognized best practices are favoured for the provision of grants, and researchers are therefore incentivized to submit their interventions for recognition. In addition, there is also support from local municipalities for the implementation of best practices.

One specific strategy also engages basic insurance to reimburse interventions targeting physical inactivity and unhealthy diet. This combined lifestyle intervention (CLI) aims to improve physical activity and dietary behaviour in overweight people through the use of recognised and evidence-based interventions. Starting in January 2019, the CLI has been covered through the ‘basic package’ of Dutch health insurance for

patients referred for treatment by a family doctor. RIVM is responsible for recognising interventions to become eligible for uptake in the insurance package.

Along with improved dissemination strategies and financial incentives, RIVM also offers various support strategies to promote implementation of best practices. RIVM works to closely adapt messaging around best practices to adjust to local context and focuses on providing information on the core elements of a best practice. Core elements are defined as: "*Central to its theory and logic. Are thought to be responsible for the effectiveness of the intervention. Critical features of the intervention intent and design. Should be kept intact when programme is implemented*."[5] RIVM defines two different types of core elements. The first are content elements related to theory and logic model. The second are practice elements related to context, cost and other specific implementation factors. Dr Dale noted that it is difficult to define the core elements for complex programmes and they struggle with this element, but they are working on a future roadmap for adaptation.

RIVM also offers workshops and outreach visits to implementers to support them in the selection and adaptation of interventions. The workshops offer 'digestible information' to participants and also offer RIVM and other stakeholders to identify 'local champions' who can support the adaptation and implementation of interventions in the local context.

RIVM is also beginning to consolidate information from its database into 'What Works' dossiers (figure 12) which provide information on active elements of different groups of interventions (e.g. in the field of combined lifestyle interventions for diet and physical activity, or youth and alcohol). They include sections on 'What works,' as well as 'What probably works,' 'What's unclear' and 'What doesn't work.' There are also examples, facts and figures, and tips to support the effective implementation of the intervention in-question. Finally, there are also links to other relevant publications. To create these 'What Works' dossiers, a literature review is first conducted with a focus on commonly-described effective elements of interventions. There

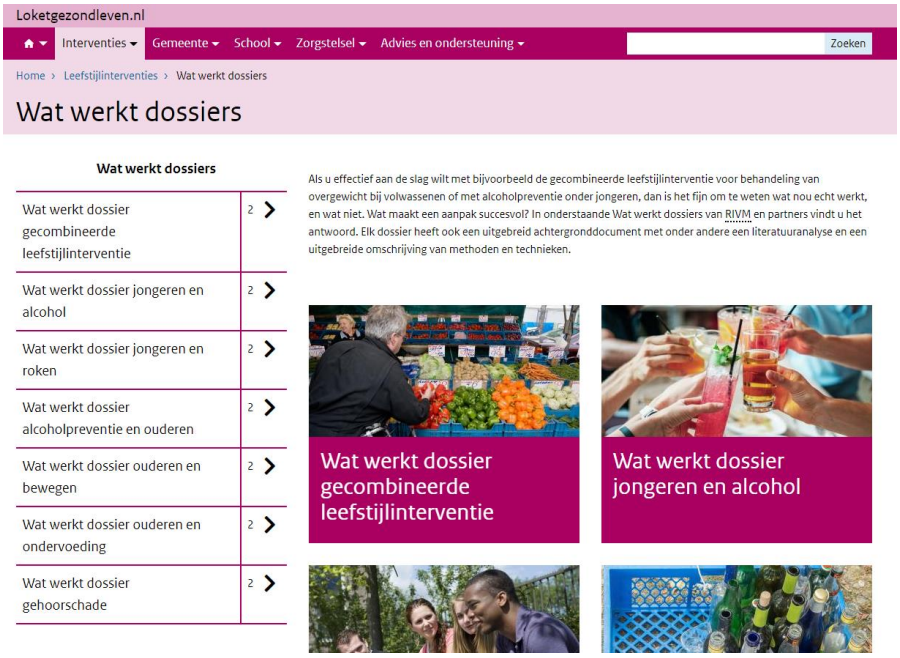


Figure 12: "What Works" dossiers from RIVM's database

5 http://www.centertrt.org/

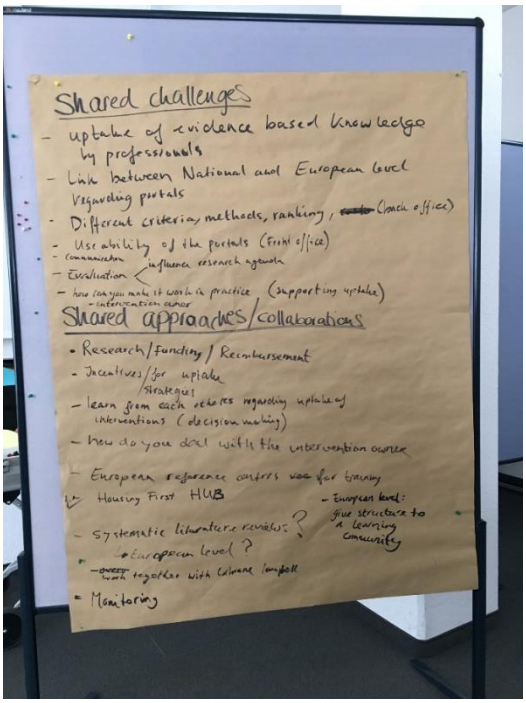
are then focus groups with relevant professionals and the development of a practical document on how to work on a specific topic area (e.g. combined lifestyle intervention).

Dr Dale concluded that after 11 years of work, they are well-known on national level. Yet, at the local level, dissemination and implementation need constant attention and support. The political support of the Ministry of Health and the Research Institute has been fundamental for scaling-up strategies and securing broad engagement from stakeholders. Other support strategies, including online and offline (e.g. workshops) capacity building have also been key to improving implementation. Finally, the 'What Works' dossiers and the future roadmap for adaptation are promising avenues for further improving the implementation of best practices.

Participants were quite interested in the core elements identified in the what works dossiers, noting that this is a relatively new area of study in this field. Dr Dale noted that there are lots of adaptation frameworks in English-language literature, and that they consistently recommend reaching out to the intervention holder and the target groups and testing. Participants also discussed whether a common taxonomy could (or should) be used for describing interventions, and whether or not it could be developed at a common level. The consensus was that it could potentially be done at a common level, as could determining the ideal 'dosage' of the programme.

Breakout Groups: Where do we stand? What are common topics? Reflection and discussions

Participants broke into two separate groups to discuss their shared challenges and the potential for common solutions.



Brainstorming during the breakout sessions

In brief, the shared challenges identified included:

- Uptake of evidence-based knowledge by policymakers and practitioners
- Clarifying and improving links between national and European-level portals
- "Back office" portal concerns: use of different evaluation criteria and methods, various scoring/ranking methodologies, different types of evidence considered
- "Front office" portal concerns: usability and engagement on portals by intervention holders and prospective intervention users
- Lack of incentives (e.g. funding, reputation) for submitting or using best practices
- Relatively low evaluation requirements in some portals
- Support framework around portals (e.g. cannot exist alone, should form part of a wider system)

- Insufficient political support and funding for establishing, remodeling and/or maintaining best practice portals

Areas of potential shared approaches and collaboration, in brief, included:

- Conducting systematic reviews (e.g. Cochrane) to map the current state of knowledge and reduce the amount of individual work for countries who would likely conduct the same types of literature reviews
- Proactively seeking out national and European best practices through further sharing of known best practices amongst portals
- Establishing a community of practice/learning community in which different portals can learn from one another's experiences
- Facilitating collaborations with intervention owners and managing potential intellectual property issues
- Establishing European reference centres to train people (including a 'training of trainers' model)
- Joining forces to seek funding and research opportunities (e.g. Joint Actions)

Participants also discussed other areas of potential collaboration, such as in the development of evaluation criteria, but it was noted that this would only be useful for those portals that are still at an early stage of development or undergoing a restructuring, as the others already use well-established criteria.

The group reconvened to discuss the outcomes from each breakout and noted that they had reached very similar conclusions. They then also took the opportunity to discuss another question: what concrete ways in which the European Commission's Best Practice Portal on Health Promotion and Disease Prevention – and the European Commission more broadly – could support the development of best practices in Europe? One of the concerns was about certification of an intervention or practice at national or European level, and non-certification at the other level. Participants wanted to ensure that national practices coming from their country (e.g. France) that were not accepted at national level would not be able to gain certification at the European level. There was also concern that not all countries had the resources and/or interest in having national portals, so they wanted to know how the Commission saw its role in such countries.

Commission participants responded with a willingness to collaborate and discuss these issues, though noting that until this time, there had never been a case of a practice being accepted at the European level that was not already accepted at the national level. When a best practice is to be awarded via the European portal, it is sent to the members of the Steering Group on Health Promotion and Disease Prevention (comprised of member state representatives) and they are given more than ten days to ensure that there are no issues with awarding this practice.

Commission officials continued by saying that it was valuable for them to be able to participate in this workshop – a first real conversation between the European and national portals – and that they wanted to see where the conversation could continue from here. They emphasised, however, that while these conversations and discussions went forward, they did not want to stop the processes that were already underway at both European and national levels.

There was also some discussion about the objectives and selected topics of the best practice portals. For the Commission, for instance, the overarching objective is to support member states to achieve the Sustainable Development Goals. Yet selected topics of the portal are largely driven by the political priorities

of the member states (e.g. cancer), not so much by objective systematic reviews. If we want an action to be funded (e.g. a Joint Action on best practice portals), it is necessary to convince the member states that there is a problem that can be addressed through such a collaboration.

The first day closed with thanks to all participants for their contributions and instructions for participating in the dinner.

4 Programme: Day Two

The second day opened with a very brief review of the primary themes and topics covered in day one. Participants were given an overview of the three final presentations that would be made today, and encouraged to participate actively in the discussion to end the workshop, in which next steps would be determined.

Database design: 'what works' by theme and target group

Making the best practice portal practical: How to encourage its use by intervention owners/submitters and public health practitioners

Prof Dr Gerard Molleman, Radboud University Medical Centre, the Netherlands

Prof Molleman gave an overview of the different roles he has held within health promotion and disease prevention portals. In various positions at local and national level he has served as a system developer, an advisor, an intervention owner, an assessor, and a manager of users. This has given him the opportunity to understand the use of best practice portals. He suggested that we needed to understand the power dynamics in each country as a first step. It is important to understand that whoever is paying will determine what is going to be done, and that local governments (at least in the Netherlands) have significant freedom to determine what they will do, particularly since national bodies do not have the power to enforce what is being done locally. So it is important for the national and local levels to work together to create ownership and ensure quality and context-appropriate health promotion activities are being conducted.

It is also important to understand the different perspectives of the intervention owner, the user, and the manager, who all have different incentives and needs. Health brokers, who also form part of the Dutch system, are a key linchpin in bringing these actors together and ensuring that best practices are used successfully. These professionals should have a certain profile and set of capacities – including good communication skills, good 'people skills', public health knowledge and competencies, familiarity with the local structure and organisations, and good project management skills.

He drew some lessons learned and key messages from the work they have been conducting in the Gelderland-Zuid region:

- Interventions must always be part of an integrated approach
- There should be a distinction between intervention owners and local users
- At the local level, the context is more important than the evidence of the intervention
- Health promoters need to be familiar with a variety of interventions and their effectiveness (the RIVM What Works dossiers are useful for this)
- In intervention assessments, the context and 'stage' of the intervention must be clearly described
- Make the implementation and identification of best practices into a learning system which takes national and local perspectives into account

Prof Molleman cautioned that all the way back in 2006, they were talking about very similar challenges, and demonstrated it with a slide of lessons learned from the Budapest IUHPE meeting on 18 October 2006. It is not enough to know our challenges: we must act on them!

He also showed a slide presented by Prof Harry Rutter at the IUHPE Conference 2019 in Rotorua, New Zealand. It shows (Figure 13) that, of all possible interventions, there are very few which have evidence of both effectiveness and cost-effectiveness. This slide demonstrates the risks of basing all of interventions on narrow pillars of stringent evidence and political support. As demonstrated in Figure 14, many of the interventions with more evidence and political support act on individual and behaviour change strategies. These risk overemphasising the role of individual choice and responsibility and can prioritise reactions to proximal risk factors rather than structural drivers (e.g., environment). This, in turn, risks both widening inequalities and promoting stigma. In order to successfully reduce inequalities and promote better health for all, it is essential to engage with social, structural, political and commercial determinants of health over the short-, medium- and long-term. This requires significant consideration of framing, systems, complexity, evidence, and much more. It is important to push interventions back upstream towards environments.

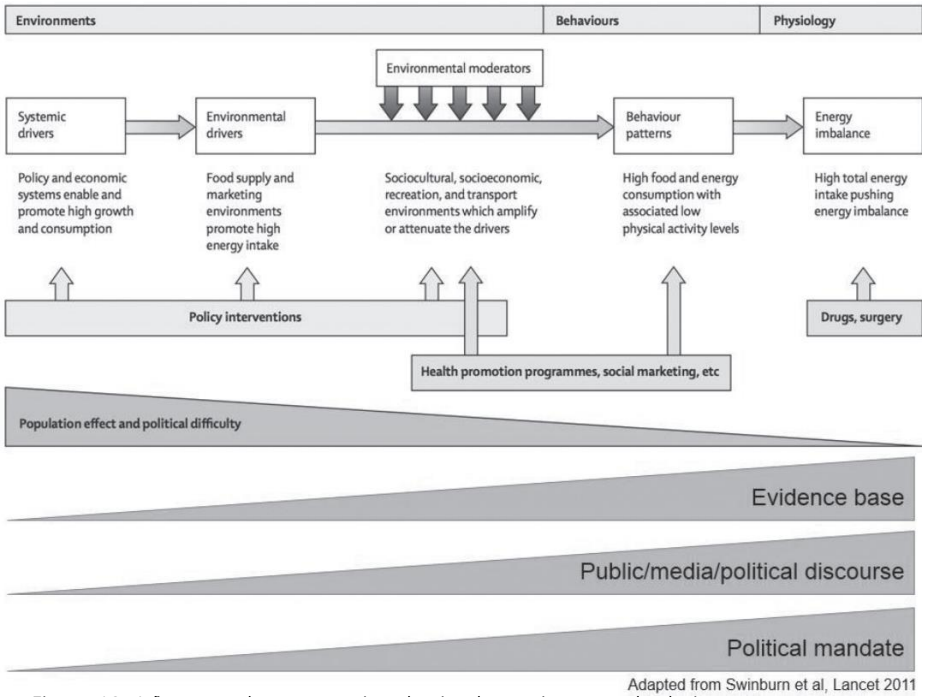


Figure 13: A framework to categorise obesity determinants and solutions

Evaluation of the Public Health Wales Good Practice Scheme

Alison Maassen, EuroHealthNet, Belgium

Ms Maassen presented data furnished by Public Health Wales on their Good Practice Scheme (GPS). They were unable to participate in the workshop directly, but also wanted to ensure that their lessons learned on developing a best practice portal were shared with the workshop participants.

The Public Health Wales Good Practice Scheme was launched in 2010 and evaluated in 2012. It aimed to recognise and support good practice in the fields of nutrition, physical activity, mental health promotion, and sexual health – as well as to support development of a knowledge-based database. It was developed based on a literature review of health promotion best practice and systems developed in the United Kingdom, Europe, Canada and the United States. It was piloted before the launch. Once launched, when the scheme did not reach the target number of applications received to the portal, Public Health Wales initiated an evaluation to analyse the application process and user experience.

A brief overview of their good practice evaluation criteria and assessment process was provided, describing the questionnaire, supplemental evidence, and responsibilities of Public Health Wales staff. The evaluation concluded that there were positives to draw from the scheme, but the main challenge was low awareness of and engagement with the portal. Only 7% of the Public Health Wales network responded to the evaluation survey, and of this group, only 42% had heard of the GPS and 8% had applied. This represents less than 1% of the total network.

Participants stated their primary reasons for lack of participation as:

- High workload and insufficient capacity for filling out 'lengthy' application (including collection of evidence for portfolio)
- Insufficient transparency regarding assessment panel and process
- Not high-profile and politically-significant enough; needs more senior management support

Following these responses, the evaluators made the following recommendations for the GPS.

1. Simplify the application process (options included online application or integrating the GPS application with funding)
2. Organising regular workshops for the PHWGPS
3. Showcase initiatives that have benefited from applying
4. Increase the promotion of the scheme and make it higher priority for senior management
5. Make PHWGPS more visible on network and PHW websites
6. Nominate a member of staff to work solely on PHWGPS
7. Develop a registry to record all initiatives across Wales to make practitioners aware of what has been tried and was successful or unsuccessful
8. Make the application process more transparent to practitioners (e.g. how does the assessment panel reach decisions?)

As of the time of the workshop, the GPS is still available online as a static tool, but Public Health Wales has determined not to continue active management of a best practice portal for the time being.

Cost-effectiveness of prevention

Dr Paul van Gils, RIVM, the Netherlands

Dr Gils gave the final presentation of the workshop, describing a Dutch cost-effectiveness website, www.kosteneffectiviteitvanpreventie.nl, to demonstrate the possibilities of the website. His central objective was to find out if participants felt that it would be worthwhile and valuable to translate this website into English.

He noted that RIVM has done longstanding work in the field of health economics, and since 1995 they have conducted cost-effectiveness analyses (CEA) of lifestyle and other interventions targeted at the most important determinants of chronic disease (e.g. smoking, obesity, physical activity). They have also conducted CEA of infectious disease prevention, primarily around vaccination and screening programmes and interventions targeted at food-borne infections.

He presented five major areas and projects that they are working on related to cost-effectiveness, apart from maintaining the database on cost-effective preventive interventions:

1. Social Cost Benefit Analysis
2. Cost2Hale Project (2016-2019)
3. Economics of Prevention Project (2017-2019)
4. Cost-effectiveness of combined lifestyle interventions (2019-2025)
5. Strategic research projects (2019-2022) and other projects

Social Cost Benefit Analysis:

They are currently conducting social cost benefit analyses (SCBA) on alcohol, tobacco use, nutrition, cognitive behavioural therapy for addiction, and the prevention of toxoplasmosis. Future SCBA projects (2019-2022) will include supportive interventions for informal caregivers and increasing green/blue space in urban environments.

Cost2Hale (2016-2019):

This project which creates a matrix or “league table” of the most promising preventive interventions based on three factors:

1. Possible cost savings (i.e. health gains and cost savings)
2. Most favourable ICER (i.e. health gains at a relatively low cost), and
3. Avoidance of DALYs

They are looking at preventive interventions across a range of fields including environment, lifestyle and healthcare settings. In order to estimate costs and effects for national implementation, target groups were defined and similar estimates for realistic implementation grades were made (e.g. 1% of target population for lifestyle interventions is reached effectively in a healthcare setting annually). This project has allowed

them to calculate the top 20 cost-effective health promotion interventions based on cost per life-year gained (Figure 14).

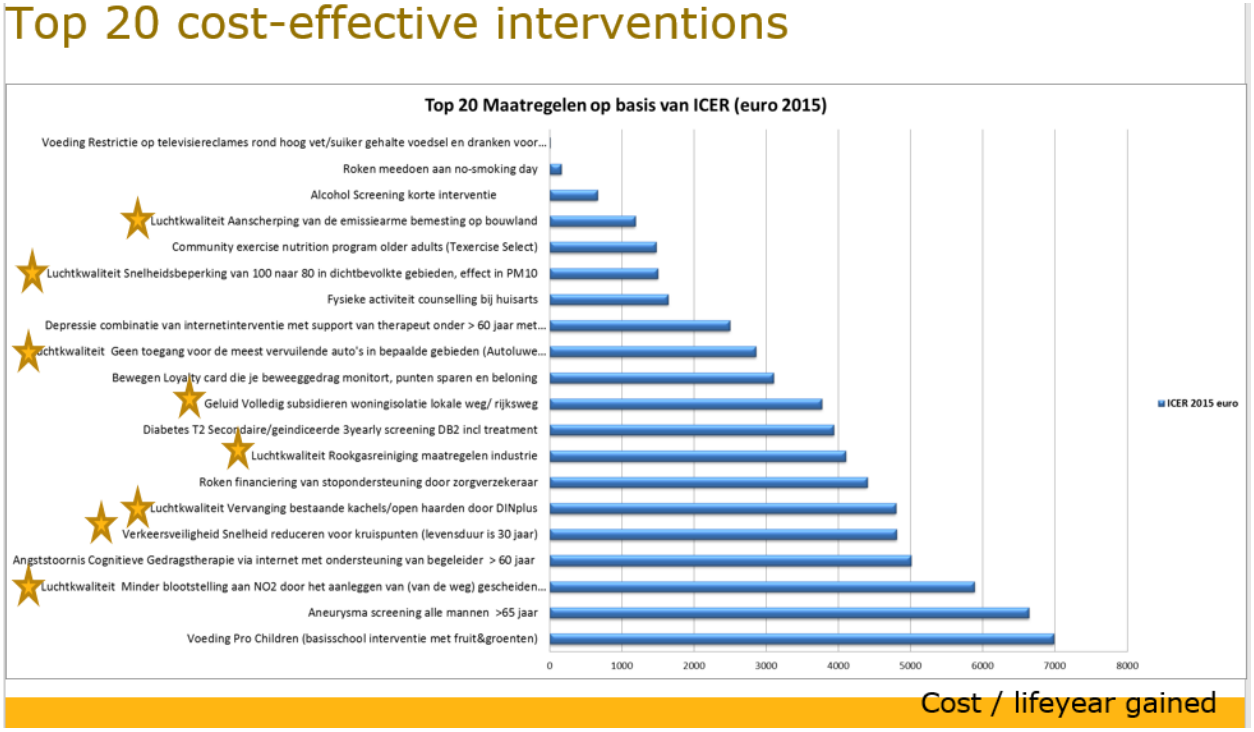


Figure 14: The top 20 cost-effective interventions based on cost per life-year gained (as calculated by the Cost2Hale project)

Economics of Cost Prevention:

This project attempts to calculate total societal expenses for prevention for citizens, companies, government, health insurance companies, and private funds (e.g. Heart Foundation, Cancer Fund). They have found that working conditions and safety are the largest area of societal expense in health promotion, followed by "general health" (e.g. municipal health service, information), mental disorders, and healthy food and overweight.

Cost-effectiveness of combined lifestyle interventions:

This project works on the combined lifestyle interventions (CLI) described in Dr Dale's presentation in day one. They are conducting a review of lifestyle interventions recently introduced in healthcare settings, and will combine register data with health insurance data and micro data from Statistics Netherlands.

Strategic Research Projects (2019-2022):

Some of the work includes a methods development (on participative value evaluation) and researching societal acceptance of reducing health insurance coverage ("willingness to accept"). They are also conducting research on the cost-effectiveness of specific interventions, including rabies prophylaxis in travellers and e-health interventions for COPD patients.

Dr Gils went on to provide further information about the development and maintenance of the cost-effectiveness database. Since 2005, they have conducted a monthly update of the literature via a specific

Figure 15: The homepage of RIVM's cost-effectiveness of prevention website

PubMed search strategy to refresh the database. Dr Gils guided participants through the user experience of navigating the database (Figure 15), illustrating how someone would find information. He also described the factsheets that users can access on the database. There are two types of factsheets. The first describe the effectiveness and cost-effectiveness of the primary areas of interest for the Ministry of Health, Welfare and Sport: alcohol, smoking, overweight and depression. The second are factsheets for interventions that have not yet been systematically introduced in the Netherlands but whose effectiveness and cost-effectiveness are shown in the literature.

Participants thanked Dr Gils for the presentation and indicated that it would be valuable to have the information from this portal available in English.

Exploring next steps and publicising and cross-promoting best practice portals – How can EuroHealthNet and the European Commission help in dissemination and exchange

As the workshop drew to a close, participants revisited the conversations from the day before, thinking about the potential next steps that could be taken together. There was a general consensus that further cooperation would bring significant added value. Some of the first considerations for collaboration would be around conducting joint literature reviews and sharing information. Other areas that may be considered (though would have less benefit for well-established portals) would be determining evaluation criteria and designing ranking systems. Participants were interested in opportunities to explore joint actions. As a 'simple' first step, the established portals represented in the workshop could all publicise and cross-promote one another's work on their respective portals, creating opportunities for users from one portal to learn about and access the other portals.

Both the European Commission and EuroHealthNet were asked how they may be able to support further dissemination and exchange around these themes. Commission representatives indicated that they would be able to provide support for virtual exchange and meetings via the Health Policy Platform (HPP). The EU Health Policy Platform is an interactive tool to boost discussions about public health concerns, share knowledge and best practices. This group could decide to establish an online group on the HPP that would either be open to the general public to join or closed to participants by invitation-only. Through the portal, it would be possible to organise webinars and maintain chats about various topics related to best practice portals.

EuroHealthNet suggested that the participants in this workshop may choose to form a EuroHealthNet Thematic Working Group, or TWIG, which would take the initiatives from this workshop forward. The new TWIG terms of reference were just agreed the week before at the General Council Meeting in Madrid, and, if organised, this would be the first group operating under the new terms. The new TWIGs are designed to be more responsive and adaptable to the current needs of members and targeted to achieve specific objectives. EuroHealthNet staff are available to support the TWIGs in managing logistics, but it is the responsibility of members, specifically the TWIG Leader(s), to set the objectives of the TWIG and prepare meeting agendas. TWIGs are open to all EuroHealthNet members, associate members, and observers, so everyone attending this workshop would be welcome to become part of the group on a voluntary basis. Ms Maassen noted that this strategy could be combined with the suggestions from the Commission, and that the Health Policy Platform could be used to support communication and virtual meetings of the group, if desired. She encouraged participants to contact EuroHealthNet if they had any questions or if they wanted to volunteer to become the TWIG Leader for this or another new TWIG.

A number of valuable resources were shared during the meeting, and participants requested that these resources be made available to the whole group. It was agreed that they would be shared – along with the presentations and meeting report – following the meeting.

The moderators thanked the speakers for their valuable insights and experiences shared. They also thanked all participants for their contributions and active participation in intense discussions and breakout sessions. They hoped that the workshop would represent just the start of a longer-term collaboration between interested parties at both European and national levels. They then closed the workshop.